REPORT

OF THE

SURGICAL DEPARTMENT

The New York Hospital

and

Cornell University Medical College

1945

By George J. Heuer, M.D.

THE SOCIETY OF THE NEW YORK HOSPITAL
525 EAST SIXTY-EIGHTH STREET
NEW YORK, N. Y.

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To the President of the Board of Governors of the New York Hospital and the President of the Board of Trustees of Cornell University.

The termination of the war has brought the hope that we can, within a reasonable time, again get ourselves in order and pursue our care of the sick, our teaching and research under more normal conditions. I see new enthusiasms. The men who remained with us during the war and carried excessively heavy burdens are being relieved of some of their duties as men return from the Services and find themselves eager to undertake new constructive work. The men who have returned from war, long divorced from clinical and laboratory facilities of the sort we can offer, appear to be full of ideas and anxious to probe them. The department should in the years immediately ahead be very active and it is hoped that increased facilities in the way of funds, equipment and supplies may be forthcoming to meet its needs.

It is a period not alone of new enthusiasms. The past year also has been a period of appraisal of the department as a whole; and as a result we know perhaps more precisely than we have previously known the defects in the Department of General Surgery and the Specialties of Surgery and the direction along which improvements should be made. Certain improvements have already been made; and particularly in our Out-Patient Department changes in policy agreed upon with the Department of Medicine are already yielding results.

The year has also brought serious consideration of new forms of activity in which the Hospital and Medical College must decide whether or not they will immediately participate. A Health Program for a large group of individuals, the cost to be covered by prepaid insurance, has been long under discussion and more recently the advantages of a Diagnostic and Treatment Clinic are being considered. There appears to be little doubt that the hospital facilities for the preservation of health and the diagnosis and treatment of disease could successfully be greatly expanded. We have already in some respects outgrown our buildings. Our pavilion teaching beds, if not encroached upon, are adequate for our undergraduate teaching so long as we do not greatly increase our classes. They are also adequate for a limited graduate teaching program, but could profitably be expanded if we were to enlarge our graduate instruction. Our private and semi-private beds, however, are quite inadequate for our present staff; and our laboratory research facilities and endowments for research are far below our needs. Not only have we been studying health programs and other means of caring for the sick along lines in which governments presently are showing great interest, but we are studying affiliations with other institutions with the object of determining the advantages in the care of the sick, in teaching and research, of increased bed capacity, increased staff and increased endowments under one administrative control. No definite statements regarding these possible new activities can be made at the present time.

1. *Chronicle of the Staff.* Although the war has ended, a considerable number of the members of our senior and resident staffs still remain in Service. While I cannot at this writing set forth the final record of the members of the Surgical Department, it may be of interest to record some of their achievements as I know them at present. I do so with particular reference to my interest in the training of young men in surgery and my conviction that a thorough training in surgery added, without interruption if possible, to the undergraduate course in medicine and the internship, will equip a man at a reasonably early age, not only to do a high quality of surgery but to assume large responsibilities. War, being a young man's game, offers an opportunity to test these convictions.

During the war, twenty of our Residents in General Surgery who had completed their residents' training (average six years),

thirty-one Assistant Residents of various periods of training, and 34 interns entered Military service. I shall not record the careers of this large group but shall state only the top positions in Military surgery they occupied as an index of the value of surgical training as we conceive it.

Of the twenty residents who completed their surgical training, one was Consulting Surgeon to the 6th Army, fifteen were Chiefs of surgical services of hospital units (general hospitals 10, Evacuation hospitals or Station hospitals, 5) and four were assistant chiefs of hospital units; three were advanced to the position of Consultant in surgery to hospital groups or to Army corps, and one was made Commanding officer of his organization.

Of the thirty-one assistant residents who entered Military service, three were Chiefs of Surgical services of Hospital units, one Assistant Chief of Surgical service, two Chiefs of Orthopedic service, one Assistant Chief of Urologic service and one Assistant Corps surgeon.

The record of the Cornell division of the Surgical Department at Bellevue Hospital is equally impressive. Some years before the War, a resident's training program comparable in most every respect to that at the New York Hospital was organized. Five men at our entry into the War, had completed their resident's training and entered Military service. All five men were Chiefs of Surgical services of hospital units and two of them were advanced to Surgical consultants. Of the Assistant residents who entered service, one was Chief of Thoracic surgery and later Consultant in Thoracic surgery, one Chief of Neurosurgery and one Chief of Orthopedic surgery.

Of the six residents in Urology who had completed their training at the New York Hospital and who entered Military service, three were Chiefs of Urologic services of hospital units, two served in the Navy on combat ships, and one, inducted after the end of the War, is now in service.

Of the residents, assistant residents and interns above considered, eighteen received thirty-six citations for outstanding work. Ten of the hospital units of which they were Surgical Chiefs, received unit citations.

A summary of the above statements shows that one Surgical Department, through a program of surgical training, furnished

for the service of the wounded the top men in Surgery for twenty-three Hospital units, the top men in the Specialties of Surgery of nine Hospital units and the important second string men of five Hospital units. It furnished also six Consulting Surgeons for Hospital groups and Army Corps. And this does not take into consideration the contribution made by the very large number of young men who, when they left us, were beginning, or had completed only a part of, their surgical training.

The reason for presenting this record is indicated above. The record furnishes an additional argument in favor of an organized program of surgical training in University Hospitals or other hospitals affiliated with teaching centers, the ward beds of which are adequate to train a group of young men. It is a record which should be of great interest to the Surgeons General of the Army and Navy and particularly to the Veterans Administration. Never before in our history has the United States Veterans Administration been faced with so large a problem, for statements are in print to the effect that this Governmental Agency must envisage the care of some 18,000,000 veterans when they are sick. I doubt if a program for the adequate care of such a number can satisfactorily be developed which does not include a program for the proper training of young men in medicine and surgery. Nor will a program for the proper training of men be so likely to succeed unless done in close connection with the Medical Training centers of the country.

In addition to the Residents, Assistant Residents and Interns above considered, fifty-six members of the Senior and Clinic staffs of the Surgical Department, including thirteen Dentists, served in the Army, Navy and Air Force. Of this group, one was the Commanding Officer of an Evacuation Hospital, two were Surgical Consultants of Army Groups, five were Chiefs of Surgery of Hospital Units, one Chief of the Orthopedic Section, Air Force, one Chief of the Urologic Service of a hospital unit, and one Chief of Neurosurgery of a hospital unit. Four of the men in this group received eight citations for outstanding work including three unit citations for the hospitals with which they were associated.

During 1945, James A. Dingwall completed his resident's training and was succeeded by Bernard Maisel. Charles S. Jones and Arthur D. Console continued as residents. The Assistant

Residents during the year were Guy B. Maynard, Jr., Charles Neumann, Oliver J. Purnell, Jr., David M. Lin-Yuen, Harold S. Auerhan, N. Miles Fellows, Frances W. Lovejoy, Armin A. Darmstaetter, Jr., Sam R. Burnett, Russell H. Hooker, William C. Quinn, Warren F. Eberhart, William C. van der Lieth, David W. Barton, Howard S. Dunbar, Francis Z. Reinus, and Ross S. McElwee, Jr. Of this list, Drs. Burnett, Hooker, Quinn and Gill are former assistant residents who have returned to us after discharge from Military service. New Interns appointed as of July 1, 1945 were George M. Longbothum, Merle M. Mahr, Howard S. Jeck, Jr., Byron E. Howe, Jr., Robert C. Emmel, all graduates of Cornell University Medical College; Roy D. McClure, Jr., Johns Hopkins Medical School, Harry C. Bishop, Harvard Medical School and Henry F. Kramer, College of Physicians and Surgeons.

During the year construction of additional offices for our part-time men was begun and at this writing (May, 1946) is completed. Ten offices have been made available in addition to the offices already provided for general surgery and the specialities of surgery. The addition of these offices is believed to be of great importance to the surgical department and the Head of the department takes this opportunity to thank the Board of Governors of the Hospital for providing them. The part-time men selected to occupy them are those in general surgery and the specialties of surgery who are particularly concerned with the care of patients in our wards and out-patient department, in teaching and research. They have agreed not to have offices outside the hospital but to see their private patients in their hospital offices. They have become "geographical" full time men and I have no doubt the department will benefit greatly by the arrangement.

II. Service to Patients.

A. *General Surgery.* Pavilion Service. During the year 1945, 2620 patients were admitted to the pavilion beds of general surgery, a decrease of 185 as compared with the year 1944. During a large part of the year a pavilion of 23 beds was closed due both to lack of nursing personnel and to lack of equipment. This fact accounts for the decrease in admissions and it is hoped the pavilion may soon be opened.

Of the 2620 patients admitted, 557 were not subjected to operation and of this number 13 died in the hospital; a nonoperative mortality of 2.3 per cent. Autopsies were obtained in 8 or 61 per cent of the patients who died. The deaths are listed in Table I.

Upon the remaining 2063 patients, 2469 operations were performed with 35 hospital deaths; an operative mortality of 1.4 per cent, a case mortality of 1.7 per cent. Autopsies were obtained in 28, an autopsy percentage of 80. The operations are listed at the end of this report. The postoperative deaths are listed in Table II. Of the total number of operations, 237 were performed for various varieties of herniae without a post-operative death; 196 for appendicitis with its various complications with 2 deaths; 127 for diseases of the thyroid gland without a death; 142 for noncancerous diseases of the gallbladder and biliary tract with 4 deaths; and 212 for noncancerous diseases of the rectum and anus without a death. In these most common conditions there were, therefore, 914 operations with 6 postoperative deaths, a surgical mortality of 0.6 per cent. The distribution of operations according to regions with the postoperative mortality may be shown as follows:

	Operations	*Deaths*	*Mortality*
Head and Face	100	0	0%
Brain, Spinal Cord and Peripheral Nerves	242	9	3.7%
Neck, including Thyroid Gland	162	0	0%
Thorax, including all intrathoracic lesions	194	6	3.%
Abdomen, including Herniae, Rectum and Anus	1103	20	1.8%
Extremities	425	0	0%
Skin and Subcutaneous Tissues	243	0	0%
Total	2469	35	1.4%

It will be observed that all our postoperative fatalities occurred in Neurosurgery, Thoracic Surgery and Abdominal Surgery; as is to be expected. Our postoperative mortality in radical surgery for cancer in all locations was 4.2 per cent.

B. *Urology. Cornell Pavilion Service.* There were 489 patients admitted upon whom 344 urological operations were performed. Thirteen patients died in the hospital following operation, a surgical mortality of 3.7 per cent. The deaths are listed in Table III and show that of the 13 deaths, 9 occurred in cancer.

C. *Urology. Brady Foundation.* Three hundred and two patients were admitted to the pavilion beds of this service, upon whom 312 operations were performed. There were 5 postoperative deaths in the hospital, a mortality of 1.6 per cent. The postoperative deaths are listed in Table III.

D. *Otolaryngology.* This service admitted 460 patients to its pavilion beds and performed 309 operations with 1 postoperative death. The death is listed in Table III.

E. *Ophthalmology.* The admissions to this service totaled 324. Three hundred and twenty operations were performed without a postoperative death.

F. *Semiprivate and Private Services.* General Surgery and the Specialties of Surgery admitted a total of 3427 semiprivate and private patients to the George F. Baker Pavilion, a decrease of 45 patients as compared to 1944. Three thousand six hundred and forty-nine operations were performed with 70 postoperative deaths, an operative mortality of 1.9 per cent.

G. *Summary of In-Patient Services.* General Surgery and the Specialties of Surgery admitted a total of 7622 patients upon whom 7403 operations were performed. There were 124 postoperative deaths, an operative mortality of 1.6 per cent. Of the total admissions, the pavilion admissions make up 55 per cent, the semiprivate and private admissions 45 per cent. Of the total number of operations, those upon pavilion patients are 50.8 per cent, those upon semiprivate and private patients 49.2 per cent. It appears that in Surgery the admissions and operations performed upon private patients will soon equal the admissions and operations of our pavilion teaching services.

H. *Ambulant and Out-Patient Services.* During the year General Surgery and the Surgical Specialties received 16,224 new patients in the Out-Patient Department and a total of 87,401 patient visits. The distribution of new patients and patient visits among the various subdivisions of the department is as follows: General Surgery, 6115 new patients and 35,422 patient visits; Urology (both Urologic services) 1739 new patients and 13,720 visits; Orthopedic surgery 1706 new patients and 6275 patient visits; Otolaryngology 2725 new patients and 10,010 patient visits; Ophthalmology 2735 new patients and 13,604 patient

visits; Peripheral Vascular, 223 new patients and 3833 patient visits; Dentistry 981 new patients and 4537 patient visits. In addition, the Accident Pavilion admitted 10,393 new patients and received 13,495 visits; the Department of Physical Therapy gave 26,719 patient treatments; the Surgical Follow-Up Clinic received 3996 patients for reexamination. The various units of the Department received, then, a total of 131,611 patient visits. In the Out-Patient Department operating rooms 429 minor surgical operations were performed and 993 plaster casts were applied.

The compensation work has increased in the past two years. During 1945, 1259 compensation cases were referred to members of the Surgical staff and made approximately 2575 visits. In our "overrate" consultation service 668 patients were referred to surgeons.

I. *Surgical Pathology.* The Surgical Pathological Laboratory under the direction of Dr. N. C. Foot received, described, diagnosed and recorded 5162 surgical pathological specimens received from the operating rooms, in-patient pavilion services and out-patient department.

J. *Anesthesia.* The Subdepartment of Anesthesia under the direction of Dr. Mary Ward reports on the administration of 5125 anesthetics. This number is exclusive of the anesthetics given by our special anesthetists, Drs. Ella Hediger, Rose André and Hans H. R. Polano. The distribution of anesthetic agents used is as follows: Ether alone or supplemented by other anesthetic agents, 2946; local, occasionally supplemented, 464; spinal, occasionally supplemented, 682; avertin (basal), 500; cyclopropane, 203; pentothal, 166; nitrous oxide alone, 76; vinethene, 96; caudal, 26; miscellaneous, 32.

Following anesthesia there were 70 postoperative pulmonary complications which, on analysis, may be related to anesthesia; 6 circulatory complications and 1 postoperative hepatic failure which may have been associated with anesthesia. This is a total of 77 complications in 5125 anesthesias, an incidence of 1.5 per cent. A further analysis of these complications shows the following:

1) *Pulmonary complications.*
   a) Pulmonary atelectasis without pneumonia, 16. Fifteen patients recovered; 1, with massive atelectasis and failure of respiration died one hour after operation.

b) Pulmonary atelectasis followed by pneumonia, 26. Of these patients, 24 recovered; 1 died 34 days after operation from cardiac failure; 1 died 3 months after operation from advanced carcinoma. Neither death can be attributed to anesthesia.

c) Lobar pneumonia, 8. Five patients recovered; 2 patients died from massive tuberculous pneumonia following operations for pulmonary tuberculosis; 1 patient died of carcinoma of the pancreas with pulmonary metastases. Two of the 3 deaths can be related to anesthesia.

d) Bronchopneumonia, 19. All recovered.

e) Pulmonary infarction, 1. Recovered.

2) *Circulatory complications.*

a) Coronary occlusion in early postoperative course, 4. All recovered.

b) Shock with circulatory failure, 1. Died.

c) Cardiac fibrillation, thyroid, 1. Recovered.

3) *Unclassified complications.*

a) Postoperative hepatic failure, 1. Died.

A summary of the year's experience shows that there were 77 complications which may be related to anesthesia, an incidence of 1.5 per cent. The total deaths which can be related to anesthesia are 4; a death rate from anesthesia of 0.07 per cent and a mortality in those with complications (4 in 77) of 5.2 per cent. Three additional patients in the group of 77 died in the hospital but their deaths cannot be related to anesthesia.

In connection with the above statements, I present the total postoperative pulmonary and circulatory complications which occurred during the hospitalization period of the 5125 patients subjected to anesthesia whether or not they were related to anesthesia. The total number of complications was 113 and of these 91 were pulmonary; 21 were circulatory and 1 a postoperative hepatic failure. Of the 91 *pulmonary complications*, 21 were diagnosed as pulmonary atelectasis without pneumonia. Of these one died. Twenty-seven were cases of atelectasis with pneumonia, and of these 1 died 34 days after operation from cardiac failure, and 1 died 3 months after operation from advanced cancer. Ten were examples of lobar pneumonia of which 2 died from massive tuberculous pneumonia; 1 eventually died of carcinoma of the pancreas and 1 died from pulmonary aspiration during tube feeding.

Twenty-four were patients with bronchopneumonia of whom 1 died who had a tracheoesophageal fistula. Nine developed pulmonary embolism and infarction of whom 4 died. One had respiratory failure of unknown origin from which he died. There were, therefore, in these 91 cases with pulmonary complications, a total of 13 deaths of which 4 may be related to anesthesia. Of the 21 *circulatory complications* there were 10 cases of coronary occlusion (2 large myocardial infarcts) with 2 deaths; 2 of cerebral accident with recovery; 3 of acute rheumatic fever or subacute bacterial endocarditis with 2 deaths; 2 of hemorrhage or shock with 2 deaths; 2 of cardiac decompensation or congestive failure with 1 death; 1 of cardiac fibrillation with recovery; and 1 of transfusion reaction with death. Of the 21 patients with circulatory complications, 8 died. The single unclassified complication—a postoperative hepatic failure with death—is noted above. Whether it was or was not related to anesthesia remains problematical.

In view of the present interest in the prevention of pulmonary embolism and infarction by ligation of the major veins of the lower extremity, I add a note with reference to the 9 cases of this condition which occurred postoperatively in the 5125 cases here considered. The incidence is 0.17 per cent; the mortality following this condition is 0.07 per cent. Of the 9 cases, 6 developed embolism and infarction before there was any evidence of thrombophlebitis. In 5 of the 6 cases evidence of thrombophlebitis failed to appear at any time; in 1 case evidence of thrombophlebitis appeared several days after infarction. In 2 of the 5 cases without evidence of thrombophlebitis at any time, the initial embolism and infarction was fatal; in one immediately, in one after a few days; in 2, bilateral venous ligation was practiced after the initial infarction with recovery in one, but with death in the other from a second infarct; in one without venous ligation recovery occurred. In the one case in which evidence of thrombophlebitis occurred subsequent to infarction, the veins were ligated with recovery.

Three of the nine cases showed evidence of thrombophlebitis before the initial infarction. One had almost immediately afterward the initial fatal embolism. The other two were subjected to venous ligation following the initial infarcts and recovered.

K. *Follow-Up Department.* The Department, under the direction of Dr. Bronson S. Ray, sent out 14,151 letters and other

communications requesting the return of former patients to our Sunday morning Follow-up Clinic. As a result, 3996 patients returned to the Sunday Clinic for examinations; 2124 answered by mail; 869 answered by telephone, and 785 were examined outside the Sunday clinic. Fairly accurate information for our follow-up records was obtained, therefore, in 7774 former patients. Of the 7774 patients, 1247 were referred to our Out-patient Department for further examination, 100 were advised to reenter the hospital because of new or the continuance of old conditions and of the 100, 62 reentered the hospital before the close of the year. At the end of 1945, the department was carrying 9078 current cases and had closed 19,222 cases. Of the cases closed during the year, 95.3 per cent were closed with satisfactory follow-up records. Of the total cases closed since the department started its work, 88.7 per cent have been closed with satisfactory follow-up records.

III. Teaching. The teaching of surgery began in the last trimester of the second year with a series of introductory exercises on the fundamental principles of surgical technique, certain special diagnostic procedures, and anesthesia. During the surgical trimester of the third year the students have spent their mornings on the wards, receiving instruction at the bedside and as clinical clerks working up cases assigned to them. This experience has been supplemented by reading and clinical demonstrations. The afternoons have been given over to the specialties of surgery, including clinics in Urology, Otolaryngology, Ophthalmology and assignment to the Out-Patient departments in these specialties.

One-half of the surgical group of fourth year students worked in the Out-Patient department in the clinics of general surgery, while the other half had further experience in the wards of the hospital. As originally arranged in the curriculum, this latter group was to function as clinical clerks on special types of cases, but due to the curtailment of house staff, the result of War, they have done the work of interns. In fact, for most of the year at least half of the fourth year surgical group substituted as interns in the hospital pavilions.

During the past year traumatic surgery and other aspects of surgery applicable to service in the armed forces has again been emphasized. These subjects have been presented in weekly seminars at which such subjects as shock, burns, wounds of the chest,

of the central nervous system, of the abdomen, etc., have been presented by students who have prepared papers on subjects assigned to them; the presentations being followed by open discussions led by a member of the surgical staff. These exercises have been enthusiastically participated in by the students and they have proven to be a satisfactory method of instruction.

During the year the operative course on animals conducted in our surgical experimental laboratory which, during the War, had to be abandoned, has been reinstituted and is again a very popular course. Tentative arrangements have been made and, I hope, soon will be put into effect, to teach fourth year students in surgery at Bellevue Hospital. In our graduate teaching program, arrangements also have been made to exchange residents with the Second Surgical Division at Bellevue Hospital.

I should not leave the subject of teaching without again calling attention to the great advantage, both from the viewpoints of teaching and research, of greater financial support of the subdepartments of surgery. Recently I have again studied the matter with those concerned and I believe very satisfactory results could be obtained if budgets no larger than $20,000.00 per year could be allocated each to Ophthalmology, Otolaryngology, Urology and Orthopedic Surgery. Similar budgets should, sooner or later, be allocated to Neurosurgery, Plastic Surgery and Thoracic Surgery; and to the General Surgical and Urological units of the Second Surgical Division at Bellevue Hospital.

IV. Research. During the year 1945, the following projects were carried on in the Laboratory of Experimental surgery: 1) a study of the effects of adult tissue extracts on tissue growth with particular reference to wound healing; 2) further studies on the effect of pedicle jejunal grafts in the wall of the stomach on gastric secretion; 3) studies on methods of closure of tracheobronchial stumps following high amputation of the main stem of the bronchus; 4) studies on a method of ureteral implantation into the large bowel; 5) studies on heterotransplantation of the kidney.

The Surgical Department has been selected as one of the centers to study the effects of streptomycin on certain infections. The work will be in charge of Dr. Frank Glenn. A laboratory for Surgical Bacteriology is being developed to carry it on and we are anticipating some interesting research in this field.

PAPERS which are completed and may or may not have been published by the time this report is printed are listed below. The list is, of course, an incomplete one for it has been impossible to obtain the publications of all members of the staff still in service.

GRANTS IN AID OF RESEARCH

for the year 1945.

Macy Tissue Fund	$ 3,200.00
Given Fund	5,000.00
Surgery, Urology Fund	25.00
James Foundation, Ophthalmology Fund	3,000.00
Alice R. Bernheim Fund	2,700.00
Total	$ 13,925.00

PAPERS COMPLETED

ANDRUS, WILLIAM DeW.
Transthoracic approach for atresia of the cardiac orifice of the stomach.
Treatment of Aneurysm of the common iliac artery.

HEUER, G. J.
Treatment of chronic constrictive pericarditis. (Roger Morris Lecture, Cincinnati, 1945)
Symposium on War Wounds (Surgical section N. Y. Academy of Medicine)
Panel discussion: Surgery of the Gallbladder.
Annual report of Surgical Department for 1944.

RAY, BRONSON S.
Surgical Measures for the Relief of Pain. N. Y. State M. J.
Studies on Pain: Spread of Pain. Evidence on the site of spread within the neuraxis of the effects of painful stimulation. (with Wolff, H.)
Surgical Treatment of Hypertension. N. Y. State J. M.
Differential diagnosis between ruptured intervertebral disk and neurological conditions in the spine. S. Clinics N. A.

LORD, J., JR.
Nonsuture method of blood vessel anastomosis. J. A. M. A. 127: 685, 1945

KIRWIN, J. T.
A new cystoscope. J. Urology 55: 208, 1945

SOLEY, P. J.
Ureteropelvic obstruction in children. J. Urology 55: 46, 1945

MARSHALL, V.
Subtotal perineal prostatectomy. J. Urology 52: 250, 1945
Evaluation of Coffey I method of ureterointestinal anastomosis. Surg., Gyn. & Obst. 81: 559, 1945

DAVALOS, A.
New technique of simultaneous ureterointestinal anastomosis. J. Urology 54: 357, 1945
Rarity of stones in the urinary tract in the wet Tropics. J. Urology 54: 182, 1945

PALOMO, A.
Evaluation of thrombin following urethral resection. J. Urology 53: 166, 1945
Carcimona of the prostatic gland. J. Urology 53: 166, 1945

COOPER, W. A.
Review of cases of peptic ulcer.

ECKEL, J.
Review of cases of mediastinal tumor.
Monthly report of essential technical medical data (during the War).

GENVERT, H.
History of the unit (every six months during the War).

GLENN, F.
Graduate training in surgery.
Review of 1545 herniae.
Surgical treatment of acute cholecystitis.

MORRISON, D.
Operative risk in cardiac patients.

HOLMAN, C.
Phosphorus burns with particular reference to systemic phosphorus poisoning.
Report of casualties in the Arawe Campaign.

CONWAY, H.
Pulsating hematoma, false aneurysm and arteriovenous fistula due to War injuries. (with Plain, G.) Surgery in press.
Battle casualties from the Philippine Islands; analysis of 4040 cases. (with Coldwater, K.) Surgery in press.
Anaerobic infection and gangrene of War wounds from the Philippine Islands. Surgery in press.
Principles in reparative plastic surgery; experiences in a general hospital in the Tropics. (with Coldwater, K.) Surgery in press.
Anaerobic infection and gangrene in War wounds. J. Milit. Med. in the Pacific 1: 68, 1945

HANLON, R.
Treatment of urinary incontinence in vesical paralysis. J. Urology 53: 572, 1945

McLEAN, J.
Surgery of superior oblique muscle.
Detached retina in aphakia.
Soft glaucoma.
Work with O.S.R.D. and R.M.R. during War, not released for publication.

LOWSLEY, O.
Plastic operations on the kidney. J. Internat. Coll. of Surgeons 8: 37, 1945
Surgical aspects of cystic disease of the kidney. J.A.M.A. 127: 1112, 1945
Plastic operations on external genitalia. N. Y. Medicine 1: 20, 1945

LINS, B. E.
Solution of incrustations in the urinary bladder by a new method. J. Urology 53: 702, 1945.

TABLE I.

Nonoperative: 13

NUMBER	AGE	CONDITION ON ADMISSION	CAUSE OF DEATH	AUTOPSY
403863	54	3rd degree burns	Toxemia	yes
392659	10	3rd degree burns	Toxemia	no
403816	74	Cancer of pancreas	Cerebral accident	no
408843	44	Perirectal abscess	Coronary occlusion	yes
319262	38	Tuberculosis	Coronary occlusion	yes
411532	55	Skull fracture	Coma	Medical Examiner
413922	20	3rd degree burns	Toxemia	Medical Examiner
409929	71	Lesion of stomach	Hypoproteinemia	no
413908	42	3rd degree burns	Toxemia	Medical Examiner
414818	58	Cancer of colon	Uremia	no
416083	71	Multiple fractures of pelvis	Shock?	yes
272397	70	Acute obstructive jaundice	Toxemia	no
428693	27	3rd degree burns	Toxemia	yes

TABLE II.

Postoperative: 35

Emergency: 6

NUMBER	AGE	PRIMARY CONDITION	OPERATION	CAUSE OF DEATH	AUTOPSY
410965	69	Perforated appendix	Appendectomy	Coronary occlusion	yes
125998	49	Gastrointestinal hemorrhage	Exploratory laparotomy	Extensive cancer	no
423723	65	Acute intestinal obstruction	Cecostomy	Toxemia ?	no
275829	5	Acute appendicitis	Appendectomy	Active rheumatic heart disease; pulmonary embolism	no
306529	59	Perforated duodenal ulcer	Plication ulcer	Coronary occlusion	yes
326710	67	Bile peritonitis; ruptured gallbladder	Exploration	Peritonitis	yes
Cancer: 9					
402039		Cancer of sigmoid	Colostomy	Cancer of liver, gas gangrene	yes
407738	44	Cancer of stomach	Gastrectomy	Shock ?	yes
412503	47	Cancer of colon	Cecostomy	Ileus	no
267842	54	Cancer of lung	Pneumonectomy	Respiratory failure	yes
415133	47	Cancer of prostate	Cordotomy for pain	Respiratory failure	yes
425751	53	Cancer of stomach	Gastrectomy	Shock ?	yes
425586	54	Cancer of esophagus	Transthoracic resection	Respiratory failure	no
426709	67	Cancer of rectum, obstruction	Colostomy	Wound infection, pulmonary embolus	yes
427111	62	Cancer of lung	Pneumonectomy	Shock ?	yes

General Surgical Deaths—*continued*

Thoracic: 3

NUMBER	AGE	PRIMARY CONDITION	OPERATION	CAUSE OF DEATH	AUTOPSY
405442	58	Mediastinal mass	Thoracotomy	Pneumonia	yes
398436	23	Pulmonary tuberculosis	Lobectomy	Pneumothorax	yes
357327	48	Pulmonary tuberculosis	Fifth thoracoplasty	Dyspnea; respiratory insufficiency	yes

Brain, Spinal Cord and Nerves: 8

307894	80	Intractable pain	Rhizotomy	Coronary occlusion	yes
412885	14	Pineal tumor	Partial removal	Coma	yes
99421	44	Subtentorial tumor	Craniotomy	Intracranial pressure	yes
416090	62	Meningioma	Resection	Coma	yes
421861	7 mos.	Hydrocephalus	Coagulation choroid plexus	Hyperpyrexia	yes
431052	83	Tumor neck	Rhizotomy	Cardiac failure	no
429293	62	Brain tumor	Removal	Coma	no
431703	22	Aneurysm carotid artery	Occlusion	Sudden collapse	yes

Gallbladder: 4

245696	72	Acute cholecystitis	Cholecystectomy, colostomy	Myocardial infarction	yes
36604	62	Obstructive jaundice	Cholecystectomy, choledochotomy	Anuria	no
403583		Obstructive jaundice	Choledochostomy	Persistent jaundice	yes
411366	60	Stone in common duct	Choledocholithotomy	Coma	yes

Miscellaneous Gastrointestinal: 4

404455	3 mos.	Hepatic disease	Biopsy	Shock ?	yes
421390	Newborn	Atresia duodenum	Gastroenterostomy	Shock ?	yes
402853	36	Gastric ulcer	Gastrectomy	Transfusion reaction	yes
425528	57	Gastric ulcer	Gastrectomy	Hemorrhage, duodenal fistula	yes

Miscellaneous: 1

410028		Pyelonephritis	Nephrectomy	Embolus	yes

TABLE III.

Urology Deaths, Stevens and Brady

Nonoperative, Stevens: 3

NUMBER	AGE	PRIMARY CONDITION	CAUSE OF DEATH	AUTOPSY
179782	45	Pyelonephritis	Uremia	yes
423726	73	Uremia	Uremia	no
427284	69	Cancer of bladder	Uremia	no

Nonoperative, Brady: 2

397502	79	Uremia	Pyelitis, uremia	no
416703	62	Cancer of bladder	Uremia	Med. examiner

Operative, Stevens: 13

NUMBER	AGE	PRIMARY CONDITION	OPERATION	CAUSE OF DEATH	AUTOPSY
401060	73	Prostatic hypertrophy	Vas ligation, orchiectomy	Cancer of stomach	yes
78536	73	Prostatic hypertrophy	Transurethral resection	Pulmonary embolus	yes
407714	66	Cancer of prostate	Orchiectomy	Pulmonary embolus	no
387385	74	Prostatic hypertrophy	Transurethral resection	Massive embolism	no
410175	64	Prostatic hypertrophy	Transurethral resection	Uremia	yes
407039	52	Cancer of bladder	Ureteral transplantation	Cancer	no
414273	22 mos.	Tumor of kidney	Nephrectomy	Aspiration of vomitus	yes
407157	82	Cancer of bladder	Ureteral transplantation	Cardiac failure	no
369332	65	Cancer of bladder	Transurethral biopsy	Cancer	no
393302	66	Cancer of prostate	Ureterocutaneous anastomosis	Shock	no
425797	73	Prostatic hypertrophy	Transurethral resection	Peritonitis	no
411780	70	Sarcoma of bladder	Resection	Sarcoma	yes
429023	71	Cancer of bladder	Ureteral transplantation	Coronary occlusion	yes

Operative, Brady: 5

NUMBER	AGE	PRIMARY CONDITION	OPERATION	CAUSE OF DEATH	AUTOPSY
170586	58	Cancer of bladder	Suprapubic cystotomy and removal	Uremia	no
211078	61	Cancer of bladder	Removal, ureterointestinal anastomosis	Cardiovascular death	no
223464	64	Cancer of prostate	Transurethral resection, cystotomy	Cardiac failure, urinary ext.	no
24890	79	Prostatic hypertrophy	Transurethral resection, vasectomy	Cardiac failure	no
407911	72	Prostatic hypertrophy	Perineal prostatectomy, orchiectomy	Diabetes mellitus, arteriosclerosis	yes

Otolaryngology Death: 1

415382	3	Hypertrophied tonsils	Tonsillectomy	Hemorrhage, shock	yes

Operations, General Surgery

HEAD AND FACE:

Excision tumor scalp	1
face	2
parotid gland	5
epulis	2
scar	1
epithelioma	1
dermoid cyst	3
cancer	1
nevus	3
sarcoma	1
Plastic on head	2
lip	4
palate	11
ear	3
Inc. & Dr. abscess scalp	1
jaw	8
Tonsillectomy	40
Miscellaneous	11
	100

BRAIN, SPINAL CORD AND NERVES:

Section of nerves	18
Sympathectomy	65
Rhizotomy	20
Splanchnicotomy	9
Suture nerve	2
Ventriculogram	21
Encephalogram	4
Decompression	7
Bone flap operation	4
Exploration cerebrum	9
cerebellum	3
Removal cerebral tumor	16
cerebellar tumor	1
For brain abscess	2
Laminectomy	11
for cord tumor	3
for intervert. disk	31
Miscellaneous	17
	242

NECK:

Thyroidectomy	127
Excision benign tumor	3
Malignant tumor	2
glands	3
Thyrogloss.d.c.	1
branchial cl. cyst	2
Inc. & Dr. abscess	7
carbuncle	5
Exploration esophagus	1
Resection cervical rib	3
Miscellaneous	8
	162

THORAX:

Radical breast amputation	38
Removal benign tumor breast	75
For abscess breast	10
Thoracotomy, clean	10
infected	4
Thoracoplasty	8
Pneumolysis	1
For mediastinal tumor	3
Pneumonectomy	3
Lobectomy	2
Pericardiolysis	2
Chest wall tumor	3
Exploration chest wall	4
Rib resection, clean	5
infected	8
Thymectomy	1
Miscellaneous	17
	194

ABDOMEN:

Appendectomy, acute	153
with drainage	19
chronic	24
Cholectystectomy, acute	66
chronic	53
Cholecystostomy	2
Choledochotomy	21
Cholecystgastrostomy	8
Common duct plastic	2
Gastroenterostomy	24
Pyloroplasty	1
Gastric resection	63
Gastrostomy	10
Rammstedt operation	3
Excision peptic ulcer	2
Plication perforated peptic ulcer	11
For duodenal fistula	6
Resection small intestine	1
large intestine	18
For intestinal obstruction	4
For adhesions	12
For intussusception	3
Colostomy	37
opening	5
closing	7
Exploration liver	2
Excision hepatic tumor	2
Splenectomy	5
Pancreatectomy	2
Exploratory laparotomy	39
Exploration wound	1
Secondary closure	4
Exploration abdominal abscess	4
Exploration rectus sheath	2

ABDOMEN: continued

For subphrenic abscess	2
Torek operation	1
Miscellaneous	8

HERNIAS:

inguinal	179
femoral	17
umbilical	22
epigastric	8
diaphragmatic	2
strangulated	9
Hydrocele	6
Other G.U. operations	1
Gynecological operations	5

RECTUM AND ANUS:

Hemorrhoidectomy	102
Dilatation rectum	8
For imperforate anus	2
Perirectal abscess	25
Pilonodal sinus	35
Fissure in ano	31
Resection rectum for carcinoma	15
Miscellaneous	9
	1103

EXTREMITIES:

Amputation toe	7
finger	10
leg	3
thigh	4
secondary	3
Excision benign tumor	33
malignant tumor	2
foreign body	9
ganglion	6
bursa	5
head of radius	1
sequestrum	6
nevus	4
semilunar cartilage	4
Synovectomy	3
Arthrodesis	7
Arthroplasty	3
Open reduction fracture femur	4
leg	3
arm	9
patella	1
Manipulation fracture	9
Pinning	6
Tendon suture, early	1
late	5
For hallux valgus	7
For varicose veins	254
Miscellaneous	16
	425

SKIN, SUBCUTANEOUS TISSUES:

Incision and drainage foot	4
hand	1
finger	4
toe	1
arm	5
leg	3
axilla	6
miscellaneous	
For carbuncle	4
osteomyelitis	8
Excision benign tumor	17
keloid	1
Biopsy bone marrow	1
skin	16
glands	40
muscle	11
miscellaneous	12
Suture laceration	1
tendon	13
Debridement	10
Secondary closure	2
Plastic, clean	10
infected	1
Grafts, Thiersch	6
pinch	35
tube	9
Kondoleon operation	1
Miscellaneous	21
	243